ARLINGTON CENTRAL SCHOOL DISTRICT
144 Todd Hill Road
LaGrangeville, NY 12540

Health Information for School Trip

Student Name _____ Destination _____

D.O.B. _____ Grade ____ Team/Teacher _____

Yes	No	Check "Yes" or 'No"
		Has your child been diagnosed with a life threatening allergic condition? If yes*, specify _____ *Students requiring medical treatment for a life threatening allergy require a doctor's order specifying the treatment
		Does your child have an allergy to medications? If yes, specify: _____
Yes	No	Does your child have any of the following?
		Asthma or RAD (Reactive Airway Disease)
		Bleeding Disorder. Specify:
		Diabetes
		Heart Problem. Specify:
		POTS or History of Passing Out Date of Last Syncopal Episode:
		Seizure Disorder. Specify type: Date of last seizure:
		Other conditions. Specify:
Yes	No	Will your child require any medication for this trip?
		If yes, please list and provide medication order forms: _____ _____

I understand that no medication may accompany my child on this trip (including over-the-counter medications such as Tylenol, etc.), without the Medication Order form completed in full and submitted to the school Health Office. All non-emergency medication will be held by a supervising adult.

Legal GuardianRelationship
(Signature)

Legal Guardian _____ Date _____

_____ Relationship _____

(Print)

Phone Home _____ Work _____

Cell

Medical Care Provider: _____ Phone # _____

_____

FOR OFFICE USE ONLY

Medication	Order Rec'd	Med Rec'd	As Needed	Daily	Student Carries	Notes